

SPENDDOWN

Purpose: A person is not eligible for Categorically Needy (CN) medical coverage when they have income and or resources above the CN standards. They may become eligible for other coverage through a process called "Spenddown." This section explains spenddown for persons who are not in institutions or receiving waiver services (i.e., COPEs, CASA, etc.). If a person resides in an institution at the time of application or is receiving waiver services, see WAC 388-513-1395.

Spenddown is made up of 3 elements which will be discussed in the following order: A. Excess Income; B. Base Periods, and; C. Spenddown Expenses.

WAC 388-519-0100 Eligibility for the medically needy program.

- (1) A person who meets the following conditions is considered for medically needy (MN) coverage under the special rules in chapter 388-513 WAC.
 - (a) A person who meets the institutional status requirements of WAC 388-513-1320; or
 - (b) A person who receives waiver services under chapter 388-515 WAC.
- (2) MN coverage is considered under this chapter when a person:
 - (a) Is not excluded under subsection (1) of this section; and
 - (b) Is not eligible for categorically needy (CN) medical coverage because they have CN countable income which is above the CN income standard.
- (3) MN coverage is available for children, for persons who are pregnant or for persons who are SSI-related. MN coverage is available to an aged, blind, or disabled ineligible spouse of an SSI recipient even though that spouse's countable income is below the CN income standard. Adults with no children must be SSI related in order to be qualified for MN coverage.
- (4) A person not eligible for CN medical and who is applying for MN coverage has the right to income deductions in addition to those used to arrive at CN countable

income. The following deductions are used to calculate their countable income for MN. Those deductions to income are applied to each month of the base period and determine MN countable income:

- (a) All health insurance premiums expected to be paid by the client during the base period are deducted from their income; and
 - (b) For persons who are SSI-related and who are married, see the income provisions for the nonapplying spouse in WAC 388-450-0210; and
 - (c) For persons who are not SSI-related and who are married, an income deduction is allowed for a nonapplying spouse:
 - (i) If the nonapplying spouse is living in the same home as the applying person; and
 - (ii) The nonapplying spouse is receiving community and home based services under chapter 388-515 WAC; then
 - (iii) The income deduction is equal to the one person MNIL less the nonapplying spouse's actual income.
- (5) A person who meets the above conditions is eligible for MN medical coverage if their MN countable income is at or below the medically needy income level (MNIL) in WAC 388-478-0070. They are certified as eligible for up to twelve months of MN medical coverage. Certain SSI or SSI-related clients have a special MNIL. That MNIL exception is described in WAC 388-513-1305.
- (6) A person whose MN countable income exceeds the MNIL may become eligible for MN medical coverage when they have or expect to have medical expenses. Those medical expenses or obligations may be used to offset any portion of their income which is over the MNIL.
- (7) That portion of a person's MN countable income which is over the department's MNIL standard is called "excess income."
- (8) When a person has or will have "excess income" they are not eligible for MN coverage until they have medical expenses which are equal in amount to that excess income. This is the process of meeting "spenddown."

- (9) A person who is considered for MN coverage under this chapter may not spenddown excess resources to become eligible for the MN program. Under this chapter a person is ineligible for MN coverage if their resources exceed the program standard in WAC 388-478-0070. A person who is considered for MN coverage under chapter 388-513 WAC is allowed to spenddown excess resources.
- (10) No extensions of coverage or automatic redetermination process applies to MN coverage. A client must submit an application for each eligibility period under the MN program.

WAC 388-519-0110 Spenddown of excess income for the medically needy program.

- (1) The person applying for MN medical coverage chooses a three month or a six month base period for spenddown calculation. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section apply.
- (2) A person's base period begins on the first day of the month of application, subject to the exceptions in subsection (4) of this section.
- (3) A separate base period may be made for a retroactive period. The retroactive base period is made up of the three calendar months immediately prior to the month of application.
- (4) A base period may vary from the terms in subsections (1), (2), or (3) of this section if:
 - (a) A three month base period would overlap a previous eligibility period; or
 - (b) A client is not or will not be resource eligible for the required base period; or
 - (c) The client is not or will not be able to meet the TANF-related or SSI-related requirement for the required base period; or

- (d) The client is or will be eligible for categorically needy (CN) coverage for part of the required base period; or
 - (e) The client was not otherwise eligible for MN coverage for each of the months of the retroactive base period.
- (5) The amount of a person's "spenddown" is calculated by the department. The MN countable income from each month of the base period is compared to the MNIL. The excess income from each of the months in the base period is added together to determine the "spenddown" for the base period.
- (6) If income varies and a person's MN countable income falls below the MNIL for one or more months, the difference is used to offset the excess income in other months of the base period. If this results in a spenddown amount of zero dollars and cents, see WAC 388-519-0100(5).
- (7) Once a person's spenddown amount is known, their qualifying medical expenses are subtracted from that spenddown amount to determine the date of eligibility. The following medical expenses are used to meet spenddown:
- (a) First, Medicare and other health insurance deductibles, coinsurance charges, enrollment fees, or copayments;
 - (b) Second, medical expenses which would not be covered by the MN program;
 - (c) Third, hospital expenses paid by the person during the base period;
 - (d) Fourth, hospital expenses, regardless of age, owed by the applying person;
 - (e) Fifth, other medical expenses, potentially payable by the MN program, which have been paid by the applying person during the base period; and
 - (f) Sixth, other medical expenses, potentially payable by the MN program which are owed by the applying person.
- (8) If a person meets the spenddown obligation at the time of application, they are eligible for MN medical coverage for the remainder of the base period. The

beginning date of eligibility would be determined as described in WAC 388-416-0020.

- (9) If a person's spenddown amount is not met at the time of application, they are not eligible until they present evidence of additional expenses which meets the spenddown amount.
- (10) To be counted toward spenddown, medical expenses must:
 - (a) Not have been used to meet a previous spenddown; and
 - (b) Not be the confirmed responsibility of a third party. The entire expense will be counted unless the third party confirms its coverage within:
 - (i) Forty-five days of the date of the service; or
 - (ii) Thirty days after the base period ends; and
 - (c) Meet one of the following conditions:
 - (i) Be an unpaid liability at the beginning of the base period and be for services for:
 - (A) The applying person; or
 - (B) A family member legally or blood-related and living in the same household as the applying person.
 - (ii) Be for services received and paid for during the base period; or
 - (iii) Be for services received and paid for during a previous base period if that client payment was made necessary due to delays in the certification for that base period.
- (11) An exception to the provisions in subsection (10) of this section exists. Medical expenses the person owes are applied to spenddown even if they were paid by or are subject to payment by a publicly administered program during the base period. To qualify, the program cannot be federally funded or make the payments of a person's medical expenses from federally matched funds. The expenses do

not qualify if they were paid by the program before the first day of the base period.

- (12) The following medical expenses which the person owes are applied to spenddown. Each dollar of an expense or obligation may count once against a spenddown cycle that leads to eligibility for MN coverage:
- (a) Charges for services which would have been covered by the department's medical programs as described in chapter 388-529 WAC, less any confirmed third party payments which apply to the charges; and
 - (b) Charges for some items or services not typically covered by the department's medical programs, less any third party payments which apply to the charges. The allowable items or services must have been provided or prescribed by a licensed health care provider; and
 - (c) Medical insurance and Medicare copayments or coinsurance (premiums are income deductions under WAC 388-519-0100(4)); and
 - (d) Medical insurance deductibles including those Medicare deductibles for a first hospitalization in sixty days.
- (13) Medical expenses may be used more than once if:
- (a) The person did not meet their total spenddown amount and did not become eligible in that previous base period; and
 - (b) The medical expense was applied to that unsuccessful spenddown and remains an unpaid bill.
- (14) To be considered toward spenddown, written proof of medical expenses must be presented to the department. The deadline for presenting medical expense information is thirty days after the base period ends unless good cause for delay can be documented.
- (15) Once a person meets their spenddown and they are issued a medical identification card for MN coverage, newly identified expenses cannot be considered toward that spenddown. Once the application is approved and coverage begins the beginning date of the certification period cannot be changed due to a clients failure to identify or list medical expenses.

WAC 388-519-0120 Spenddown--Medically indigent program.

- (1) Persons ineligible for CN or MN coverage are considered for the medically indigent (MI) program under chapter 388-438-0100 WAC. Medically indigent spenddown differs from medically needy spenddown in the following ways:
 - (a) In addition to spending down income in excess of the MNIL, the amount of countable resources which is in excess of the standard in WAC 388-478-0070 is spent down.
 - (b) The base period for MI begins on the first day of the month in which the following occurred:
 - (i) Emergency ambulance transportation; or
 - (ii) Hospital emergency room services were received; or
 - (iii) The person was hospitalized for the emergency condition.
 - (c) The base period for MI is three months and it can join retroactive and prospective months into the same base period.

CLARIFYING INFORMATION - MEDICALLY NEEDY PROGRAM:

1. The Medically Needy (MN) program provides a federal and state funded Medicaid benefit for aged, blind, or disabled persons, pregnant women, children, and certain refugees with income above Categorically Needy (CN) standards. Those standards are defined in the standards chapter of this manual. There is no TANF-related MN program for adults who have no children.
2. A person who is eligible for MN without spenddown (WAC 388-519-0100[5]) could be eligible for 3 months of retroactive coverage and 12 months of ongoing coverage.
3. There may be a difference between CN countable income and MN countable income. This results from the extra income deductions which apply to MN (WAC

388-519-0100[4]). Decisions regarding CN eligibility and MN eligibility should be based on the appropriate calculation of countable income.

4. When a client's income goes down, CN coverage is authorized for any month in the base period in which CN countable income and resources are equal to or less than the CN standards. This is necessary to provide the household with the broader scope of care available with the CN benefit.
5. Income and resource limits for the MN program are the same for the Medically Indigent (MI) program. See the Emergency Assistance category for information related to the Medically Indigent (MI) program.
6. The spenddown for persons in institutions or served by waiver programs (chapter 388-515 WAC) is determined according to WAC 388-513-1395. This is covered in the Home and Community Services manual.

CLARIFYING INFORMATION - MEDICAL EXPENSES AND SPENDDOWN

1. Medical expenses subject to payment by particular public program funds (other than Medicaid) may be used to reduce a person's spenddown. They can be verified and anticipated by the agency providing the services. The Medical Assistance Administration (MAA) has negotiated agreements with these agencies which allow both the use and the anticipation of expenses:
 - a. The Mental Health Division to insure continuity of medication (Clozapine or Clozaril.)
 - b. The Northwest AIDS Foundation to administer the AIDS Insurance Continuation Program. 1-800-945-4256
 - c. Kidney Centers in various communities to administer the Kidney Disease Program.
 - d. The King County Mental Health Division to insure continuity of mental health services. (206) 296-5213 or www.metrokc.gov/dchs/mhd
 - e. The state Department of Health AIDS/HIV Early Intervention Program (360) 236-3426.
2. Medical expenses paid by other state, county, and local public programs (using no

federal funds) may be used to reduce a household's spenddown as the expenses occur and are individually verified. Examples of such programs include, but are not limited to:

- Project Share,
 - ITA payments,
 - state and county sponsored health department services for pregnant women,
 - state and county sponsored services for persons living with AIDS,
 - state and local mental health providers.
3. Medical insurance premiums (including Medicare premiums) are always treated as income deductions and are not applied to Spenddown. They should not be used as income deductions if the MAA Coordination of Benefits Section has or will pay them. Great care needs to be taken in considering Medicare premiums since the department pays these premiums in advance. Typically, Medicare premiums are paid by the department for two months after a person's CN eligibility terminates. For questions related to insurance or Medicare premium payments, contact the MAA - Coordination of Benefits section at 1-800-562-6136.
 4. Hospital or other medical-service-provider bills, which have been written-off for business purposes (i.e., a client cannot produce a current bill or a statement of non-payment from the medical service provider), payments on the interest owed on a medical bill, and Medicare expenses that will be paid by MAA are not used to reduce spenddown.
 5. An application for MN should not be denied until 30 days after the base period has expired. It may take this long for the client to gather medical bills. In addition, if a client protests a denial of MN and can show good cause for a delay beyond 30 days, the CSO should resolve the matter, reopen the application and consider the information during the pre-hearing process.
 6. It can take private health care plans six months or more to make determinations of coverage for a medical service. Consider third party coverage carefully, however, a client's eligibility should not be unduly delayed awaiting third party information. If a bill is recent, it is reasonable for the worker to assume that the payment information will not be timely - and to consider the entire amount toward spenddown.
 7. Medical expenses transferred to a credit card may be counted toward spenddown since they remain medical obligations which are owed by the client. Unlike health insurance companies, credit card companies are not "responsible" third parties.

Insurance companies are third parties with a distinct obligation to pay for medical services.

WORKER RESPONSIBILITIES

1. Determine spenddown amounts for optional base periods (3 months and 6 months and for the retroactive base period of 3 months) and explain the advantages and disadvantages of each to the client.
 - a. If possible, talk to the client to determine their circumstances. Upcoming hospitalizations or other major expenses may make a difference in selecting a base period.
 - b. A 3 month base period may be to the client's benefit if spenddown is high.
 - c. A 6 month base period may be to the client's advantage if spenddown is low or expenses are high. Once spenddown is met, certification could be longer.

Example A client has \$30.00 per month in excess income.

Spenddown in this example would be \$90 for a 3 month base period and \$180 for a 6 month base period.

If the client has \$250 in qualifying medical expenses, a 6 month base period would be beneficial to the client since they would have a longer period of eligibility.

If the same client has no qualifying medical expenses at the time of application and anticipates no large medical needs, a 3 month base period may be in the client's best interests. This would enhance the client's opportunity to meet spenddown and obtain coverage.

2. Advise the client that the months chosen for the base period and the length of the base period cannot be changed once spenddown has been met and MN benefits have been authorized (i.e., when a Medical ID card has been issued).
3. For clients enrolled in the state Department of Health AIDS/HIV Early Intervention Program, coordinate spenddown cases with the program to ensure that continuous and unbroken coverage occurs whenever possible (360-236-3426 voice and FAX 360-664-2216).

4. When spenddown is met and benefits authorized, notify the medical service providers affected by spenddown. Those whose bills remain the responsibility of the client may continue to pursue collection for those bills. Those provider bills which will be covered by the program need to be billed to the program and the provider must cease billing the client for those covered services.